STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445292	A. BUILDING _____ B. WING _____	C 09/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEECH TREE MANOR	240 HOSPITAL LANE, PO BOX 300 JELLICO, TN 37762

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.	F 225	The facility will not employ individuals who have been found guilty of abusing, neglecting,or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report ' any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility will ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).	10/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Charles W. Wheeler, LNHA — TITLE: Administrator — (X6) DATE: 10-13-11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 225	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on review of facility policy, medical record review, review of facility investigation documentation, and interview, the facility failed to thoroughly investigate falls for three residents (#1, #2, #4) of five sampled residents. The findings incuded: Review of facility policy titled "Prevention and Reporting of Suspected Resident/Patient Abuse and Neglect" revealed, " ...Implementation and ongoing monitoring consist of the following: ...Investigation ...Injuries of Unknown Source: An injury for which both of the following conditions exist : ...source of the injury was not observed by any person or the source of the injury could not be explained by the resident, AND ...The injury is suspicious because of the extent of the injury or the location of the injury ...or the number of injuries observed at one particular point in time or the incidence of injuries over time ..." Review of facility policy titled "Incident Reports" revealed, " ...completed to study the cause ...take corrective action ...Form must be completed for every unusual or happening or incident involving a resident ...incident may be defined as an accident, injury noted ...Complete incident report ...Leave no blanks ...State oly what was witnessed. Do not make assumptions ..." Resident #1 was admitted to the facility on July 28, 2011, with diagnoses including Hypothryroidism, Degenerative Joint Disease, and Schizoaffective Disorder. Medical record review of the Minimum Data Set (MDS) dated August 15, 2011, revealed a Brief Interview for Mental Status (BIMS) score of 14 and a score of 13-15 indicated cognition was	F 225	The facility will have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations will be reported to the administrator or his designated representative and to other officials in accordance with State law(including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action will be taken. The facility will thoroughly investigate falls and other incidents/accidents affecting residents of the facility. Policy updated 9-15-11 to include form that will be completed for every unusual happening or incident involving a resident incident. An Incident Report will be complete with no blanks and will state only what was witnessed and the facts surrounding and observed at scene of incident. Incident reports will reflect possible/actual	

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F 225	Continued From page 2 intact. Medical record review of a nurse's note dated August 6, 2011, at 12:30 p.m. revealed, "noted to be sitting on floor. No visible injury ..." Review of facility investigation documentation dated August 6, 2011, revealed the person to whom the fall was reported and medications that could have contributed were not identified, and included "...Witnessed by (Name) (section was blank) ...facts observed at scene of incident: Resident found sitting on floor ...Ask the Resident what precipitated the fall ...(section was blank) ...Causative Factor: Resident was sitting in wc (wheelchair) stood up wc moved resident lost balance ..." Continued review revealed no additional investigational documentation. Interview with the Director of Nursing on September 12, 2011, at 2:55 p.m., in a conference room, confirmed the facility failed to thoroughly investigate the resident's fall on August 6, 2011. Resident #2 was admitted to the facility on October 22, 2011, with diagnoses including Macular Degeneration and Dementia. Medical record review of the MDS dated June 23, 2011, revealed the resident was severely impaired with decision-making skills, non-ambulatory, and had no history of falls. Medical record review of a nurse's note dated August 21, 2011, at 6:30 p.m., revealed, " ...flip out of chair and hit head on floor ..." Review of facility investigation documentation dated August 21, 2011, revealed the form was completed by licensed practical nurse (LPN #1) and included, "Accident ...Report ...facts observed at scene ...Resident lying in floor on R (right) side ...Causative factors: CNA (certified nursing assistant #1) was pushing the W/C the resident was sitting on."	F 225	causative factors and to help identify root cause. The Interdisciplinary Care Plan Team, consisting of the DON, ADON, MDS and Care Plan Coordinator, Dietary Manager, Social Service Director, and Activity Director, will review falls/incidents on a weekly basis. Inservice training for certified and licensed nursing staff was performed on 9-2-11, 9-6-11, 9-9-11 and 9-10-11regarding falls/incidents, documentation of incidents, Incident Reports, follow-up documentation and implementation of interventions. Interventions placed on resident's care plan on 09-15-2011. 72 hour charting will be performed on residents with incidents that result in injury by the charge nurse and will be monitored via record review and observation by the ADON	

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F 225	Continued From page 3 Interview with CNA #1 on September 12, 2011, at 10:48 a.m., revealed CNA #1 left the resident seated in a wheelchair unattended to obtain linen from a linen cart in the hallway and saw the resident fall from the wheelchair as CNA #1 re-entered the resident's room. Interview with LPN #1 on September 12, 2011, at 11:14 a.m., in a conference room, revealed LPN #1 completed the report regarding the resident's fall on August 21, 2011, the form was completed before an investigation was completed, and LPN #1 stated, " ...The talk in the room (at the time of the fall) was that the CNA was pushing the resident (in wheelchair). I don't know that's what happened. The fall investigation was filled out in error ...it contains hearsay ..." Interview with the DON on September 12, 2011, at 2:50 p.m., in a conference room, confirmed the facility failed to thoroughly investigate the resident's fall on August 21, 2011. Resident #4 was admitted to the facility on January 20, 2010, with diagnoses including Dementia and Recurent Hip Fractures with Falls. Medical record review of the MDS dated August 25, 2011, revealed the resident was impaired with decision making skills, needed limited assistance with ambulation, and had a history falls. Medical record review of a nurse's note dated August 27, 2011, revealed, " ...lying on L side ..." Review of facility investigation documentation dated August 27, 2011, revealed, "...Incident Date: 8/27/11 ...Type: Unattended Fall Witnessed by (name deleted) ...Medications that could have contributed to incident (space was blank) ...Causative factor: Resident had not slept much that nite ..." Review of a Fall Investigation, Evaluation, and Interventions form dated August 27, 2011, revealed, "...NEW Interventions: (Note	F 225	A Fall Risk Assessment will be performed on all new Residents admitted to facility. If the total score on the fall risk Assessment reveals a score of 10 or above, identifies High Risk for falls, a PT screening will be initiated and care plan will reflect their high risk status along with interventions in an attempt to prevent falls. For any resident that has a fall, an incident report will be initiated and completed with no blanks and will state only what was witnessed and the facts surrounding and observed at scene of incident. Incident reports will reflect possible/actual causative factors Along with initial interventions to prevent reoccurrence of fall; will be reviewed in Morning Meeting, Monday thru Friday. Morning Meeting attendees are: DON, ADON Administrator, Dietary Manager, Social Service Director, Maintenance Director, MDS and Care Plan Coordinator, Staff Development, Housekeeping Supervisor, Medical Records Director, The individual resident care plan will be updated by the Care Plan Coordinator to reflect the fall with interventions to prevent reoccurrence.	

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F 225	Continued From page 4 Immediate interventions implemented: (space was blank)." Interview with the DON on September 12, 2011, at 1:35 p.m., in a conference room, confirmed the facility failed to thoroughly investigate the resident's fall on August 27, 2011.	F 225	The ADON will review incident reports during Morning Meetings Monday thru Friday and report to the DON. The DON will monitor fall/incident reports through record review and report to the QA committee. The committee consists of the Medical Director, Administrator, DON, ADON, MDS Coordinator, Staff Development, Medical Records Director, Activity Director and Social Service Director QA will review falls on a monthly basis and make any further recommendations and/or interventions to be implemented if applicable.	
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on medical record review, review of facility investigation documentation, observation, and interview, the facility failed to provide adaptive devices and/or adequate supervision to prevent falls for one resident (#2) of five sampled residents, resulting in a subdural hematoma and fractured cervical spine, actual harm for Resident #2. The findings included: Resident #2 was admitted to the facility on October 22, 2001, with diagnoses including Hypertension, Macular Degeneration, and Dementia. Medical record review of the Minimum Data Set (MDS) dated June 23, 2011, revealed the resident was severely impaired with decision-making skills, moderately visually impaired, non-ambulatory, and dependent on	F 323	Resident #1 was referred to Psych services on 8-8-11; Resident ambulates with cane and does not use wheelchair. Therefore wheelchair was removed from room on 8-6-11; PT educated resident on safety with transfers and instructed to use call light and ask for assistance will all out of bed activities on 8-8-11. Resident's care plan was updated on 8-6-11 to reflect event of fall with the following interventions: Psych. Services prn; continue P.T., remove w/c from room. Pharmacy reviewed resident's medications 9-25-11.	

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F 323	Continued From page 5 staff for mobility. Continued review revealed the resident had no history of falls, had not moved from a seated to standing position, transfer was coded 2 (2 = Not steady, but only able to stabilize with human assistance). Medical record review of a Fall Risk Assessment dated June 23, 2011, revealed a score of 10 and included, " ...Total score of 10 or above represents HIGH RISK." Medical record review of a care plan in effect on August 21, 2011, and effective through September 20, 2011, revealed, " ...08/12/2010 ...Potential for injury R/T (related to) fall secondary to psychotropic medications therapy, unsteady with transfers, non-ambulatory, visual dysfunction and mental errors of senile dementia which may prevent resident from recognizing safety hazards ...remain free from injury secondary to falls ...Provide adaptive devices as needed: ...uses w/c (wheelchair) Remind resident and reinforce safety awareness ...PT/OT (physical therapy/occupational therapy) consults as needed ..." Medical record review of a recapitulation (brief summary) of physician orders dated August, 2011, revealed no documentation regarding a wheelchair and included, " ...***Safety & Devices*** May be up in G/C (geri-chair) in reclining position for comfort ..." Medical record review of a nurse's note dated August 21, 2011, at 6:20 p.m., " CNA (certifed nursing assistant) pushing resident in WC (wheelchair) stated that resident put (resident's) feet down causing (resident) to flip out of chair and hit head on floor resident noted to have open area to forehead CNA called nurse to room (resident's) ...Resident noted (to) be lying in floor on Rt (right) side in floor ..."	F 323	Resident # 2 was admitted to hospital 8-21-11 and returned 9-1-11. Foot props were attached to wheelchair by ADON and care plan was updated to reflect the foot props on 9-2-11. Foot props are to be in place on wheelchair when resident is in w/c. On 9-2-11 fall risk assessment was performed by MDS Coordinator. On 9-6-11 a Significant Change MDS was performed by MDS Coordinator on 9-12-11 a side rail assessment was performed by MDS Coordinator and determined SR to be appropriate measure. Orders received for side rails on 9-12-11 and placed on resident bed with monitoring every 30 minutes with repositioning q 2 hours and prn.CNAs will document the use of siderails and documentation will be monitored by the ADON via record review and observation. Pharmacy reviewed resident's medication	

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F 323	Continued From page 6 Medical record review of a physician's order dated August 21, 2011, revealed, "May send to ER (emergency room) to evaluate and treatment." Medical record review of a nurse's note dated August 21, 2011, at 6:30 p.m., revealed, "Ambulance service arrived and called for Lifestar (airborne medical transportation) to transport resident to (hospital) D/T (due to) head injury ..." Medical record review of an Emergency Provider Record dated August 21, 2011, revealed, " ...chief complaint: Fall injury to : forehead ...nursing home ...context: fell from wheelchair ...Impression: Subdural Hematoma/Cervical Dens Fx (fracture)." Medical record review of an Emergency Department nurse's note dated August 21, 2011, at 7:45 p.m., revealed, " ...fall from ...w/c (wheelchair), pt struck head on floor ...'star' shaped lac (laceration) to R (right) forehead ..." Medical record review of a CT (computerized tomography) C-Spine (cervical spine) dated August 21, 2011, revealed, "Reason for Exam fell from chair onto forehead ...Impression: Nondisplaced type II dens fracture with slight posterior angulation." Medical record review of a CT head dated August 21, 2011, revealed, " ...Findings: A small right posterior temporal/anterior occipital subdural hematoma measures 7 mm (millimeters) in thickness ...moderate sized right frontal soft tissue laceration is noted ..." Review of facility investigation documentation provided by the facility on September 9, 2011, revealed, "Accident ...Report ...Incident Date 8/21/11 ...State facts observed at scene of incident: Resident lying in floor on R (right) side ...Part of body Affected: Skull or scalp Type of	F 323	on 9-25-11. Resident #4 had PT screening due to fall on 08-27-11. PT screening obtained on 8-31-11. U/A on 8-27 determined resident had UTI; X-Ray on 8-27 revealed resident had dx pneumonia, treated with antibiotic tx. P.T. screening performed 8-31-11. Pharmacy reviewed resident's medications on 9-25-11. Care Plan was updated on 8-27-11. F323 The facility will ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. The facility will provide adaptive devices and /or adequate supervision to prevent falls for residents in the facility.	10/19/11 per Clarification 10/17/11 10:55 am

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F 323	Continued From page 7 Injury: Fracture ...Resident activity when ...occurred: sitting in W/C (wheelchair) ...Causative factors: CNA was pushing the W/C the resident was sitting on. when resident went into floor." Review of facility investigation documentation provided by the facility on September 12, 2011, revealed an undated handwritten statement (CNA #1), and included, " ...went into resident's room to get ...bed ready ...I did not notice the resident moving ...feet back and forth but ...did that sometimes ...I walked out of the room to the linen cart ...When I was about to enter the room, I saw (resident) falling...I tried to get to (resident) but (resident) had already fallen face first. I immediately took the wash cloths and applied pressure to (resident's) forehead. I yelled for the nurse. I noticed (resident's) foot was between the small wheel and the big wheel on ...wheelchair ..." Review of facility investigation documentation (handwritten statement (licensed practical nurse - LPN #1) provided by the facility on September 9, 2011, revealed the statement was undated and included, " ...Resident ...was lying in floor on R side blood was present on forehead and in the floor ...made preparations for the resident to go to emergency room. " Review of facility investigation documentation (handwritten statement LPN.#2) provided by the facility on September 9, 2011, revealed the statement was undated and included, " ...Resident was lying face down on floor and was noted to be bleeding. Resident also was noted to be trying to move (resident's) head ...noticed the foot pegs (wheelchair foot rests) were not on wheel chair one was lying beside ...chest of drawers and one was by ...closet ..." Review of facility investigation documentation	F 323	Resident # 2 was admitted to hospital 8-21-11 and returned 9-1-11. Foot props were attached to wheelchair by ADON and care plan was updated to reflect the foot props on 9-2-11. Foot props are to be in place on wheelchair when resident is in w/c. On 9-2-11 fall risk assessment was performed by MDS Coordinator. On 9-6-11 a Significant Change MDS was performed. On 9-12-11 a side rail assessment was performed by MDS Coordinator. Orders for Side rails on 9-12-11 and placed on resident bed with monitoring every 30 minutes with repositioning q 2 hours and prn. Pharmacy reviewed resident's medications 9-25-11. All residents charts were Reviewed by ADON, Care Plan Coordinator and MDS Coordinator along with observation, to determine if any residents had orders for assistive devices that were not being utilized or had been discontinued without physician orders. Completed on 9-19-11.	

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F 323	Continued From page 8 (handwritten statement LPN #3) provided by the facility on September 9, 2011, revealed, "8/24/11 On ...8/21/11 ...I was returning a resident to (resident's) hall ...stated that (resident) had busted (resident's) head, went into RM (room) Res (resident) was lying on Rt side with blood noted @ (at resident's) head ...foot pegs were placed by the dresser and one was by the closet or bathroom." Review of facility investigation documentation dated August 21, 2011, revealed, " ...Current Restraint/Protective Device Orders: None ...List Current Interventions to prevent falls (section was blank) ...NEW interventions: (Note IMMEDIATE interventions implemented to prevent another fall: Use of foot pedals when transporting resident." Observation on September 9, 2011, at 12:00 p.m., revealed the resident asleep in bed and a scar on the right side of the resident's forehead. Interview with CNA #1 on September 12, 2011, at 10:48 a.m., in a conference room, revealed the resident was up in a wheelchair daily prior to the fall on August 21, 2011, and CNA #1 stated, " ... (Resident) could lean forward, backward, and side to side in the chair ...(day of fall) (resident) went to supper as usual. Somebody brought (resident) back from the dining room and sat (resident) in (resident's) room. (Resident) was sitting at the end of (resident's) bed in the wheelchair ...I went out to get towels and washcloths ...at linen cart approximately one room away. Whenever I got to (the) door I saw (resident) falling forward in chair and start to slide. We'll have to pull (resident) up in chair. (Resident) did that all the time ...no seat belt or nothing ...had used a gerichair ...They tried something with (resident) in therapy and (resident) got put in a wheelchair."	F 323	The charge nurses will observe every shift for use of assistive devices with residents with orders. Utilizing record review and observation, the ADON will review orders for assistive devices and determine resident application daily M-F and report to the DON.The weekend RN Supervisor will review orders for assistance devices to determine resident application daily on weekends. The DON will monitor utilizing observation and record review to monitor assistive devices and resident applications and report to the QA committee consisting of Medical Director, Administrator DON, ADON , Social Services MDS Coordinator, Rehab Manager , Medical Records ,Dietary Manager Staff Development Coordinator , Activity Director, Maintenance Supervisor and Housekeeping Supervisor. QA will review assistive devices on a monthly basis and make any further recommendations and/or interventions to be implemented if applicable.	

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F 323	Continued From page 9	F 323		

History: Medical record review of an Occupational Therapy (OT) Evaluation dated April 12, 2010, revealed, " ...Fall Precautions ...reason for referral: ...address W/C (wheelchair) positioning needs (sitting needs) ...Safety Awareness poor ...Balance: ...Sitting poor ..." Medical record review of an OT progress report dated May 17, 2010, revealed," ...D/C (discharge) ...with w/c with L (left) side supports to decrease L lateral (side) lean, anti-thrust cushion to prevent sliding forward and B (bilateral) leg protectors ...and prevent LE (lower extremities) from sliding off." Medical record review of a physician's order dated May 25, 2010, revealed, " ...OT ...D/Cd (discharged) with side support on L side, anti-thrust cushion and swing away foot rest for W/C sitting for (upright) positioning and (increased) safety ..." Interview with LPN #1 on September 12, 2011, at 11:14 a.m., in a conference room, revealed LPN #1 was familiar with the resident, and LPN #1 stated, " ...No safety devices were used ...no postural or balance problems I know of ..." Telephone interview with LPN #2 on September 12, 2011, at 11:50 a.m., revealed LPN #2 was familiar with the resident, and LPN #2 stated, " ... (resident) usually up in a wheelchair. (Resident) previously had been in a geri-chair and one of the therapists decided (resident) would be better off in a wheelchair. I did not realize (resident) had order for geri-chair ...think a while back (therapist) made a recommendation for a wheelchair." Interview with Assistant Director of Nursing #1 on September 12, 2011, at 11:58 a.m., in a conference room, revealed the wheelchair in the resident's room was the same wheelchair the resident fell from on August 12, 2011. Observation with the Director of Nursing and COTA (certified occupational therapy assistant)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445292	A. BUILDING _____ B. WING _____	C 09/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEECH TREE MANOR	240 HOSPITAL LANE, PO BOX 300 JELLICO, TN 37762

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 10 #1 on September 12, 2011, at 12:00 p.m., revealed the resident's wheelchair had no left lateral side support and swing away foot rests were in the seat of the wheelchair. Interview with COTA #1 on September 12, 2011, at 12:45 p.m., in the 300 hall, revealed the resident had used a left lateral side support on the wheelchair at one time and no explanation for the support not being used. Interview with Assistant Director of Nursing #1 on September 12, 2011, at approximately 2:30 p.m., in a conference room, revealed the facility had no documentation the ordered adaptive equipment had been discontinued. Telephone interview with M.D. #1 on September 12, 2011, at 3:22 p.m., revealed M.D. #1 had observed the resident attempt to stand at times and he stated, " ...Sometimes (resident) would rock forward like a rocking chair ...Mistakes were made for sure ..." Continued interview confirmed the facility had failed to provide adaptive equipment and/or adequate supervision to prevent falls for Resident #1, resulting in a Subdural Hematoma and Fractured Cervical Spine. C/O: #28659	F 323		